PRINTED: 10/03/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		ONSTRUCTION	(X3) DATE SU COMPLE	
		185089	B. WIN			05/	C 11/2012
	OVIDER OR SUPPLIER TRANSITIONAL CARE	AND REHABILITATION ROSEW		550 HI	ADDRESS, CITY, STATE, ZIP CODE GH ST. LING GREEN, KY 42101	•	1112012
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 000	#18241, KY #18314 conducted on 05/02/ #18241 was substan Immediate Jeopardy and determined to ex 483.10 Resident Rig Quality of Care at F3 Administration at F5 a "J". Substandard of at 42 CFR 483.25 Q determined the facilit corrective action pricinitiating the abbrevia resulting in the deter	ial extended survey (KY and KY #18344) was 12 through 05/11/12. KY tiated with deficiencies cited. was identified on 05/09/12 kist on 02/17/12 at 42 CFR hts at F157, 42 CFR 483.25 809, and 42 CFR 483.75 14, at a scope and severity of Quality of Care was identified uality of Care at F309. It was	F	000			
	Physical Therapy As change of condition Registered Nurse (R On 02/17/12, RN #1 #1's room and conduresident. They report a change of condition of documentation the conducted or the phy 02/17/12 and 02/20/reported to RN #5, that she had observed Resident #1. There an assessment was was notified. On 02/to the Director of Nurshe had noticed a change of condition of the conducted or the phy 02/17/12 and 02/20/reported to RN #5, the conducted of the	providing care to Resident #1, sistant (PTA) noticed a in the resident. She notified N) #1 regarding the changes. and RN #2 went to Resident acted an assessment of the ted they were unable to find in Resident #1. There was at an assessment was as an assessment was as a sistent was notified. On 12, Resident #1's daughter in a 3 PM to 11 PM shift nurse, and a change of condition in was no documentation that conducted or the physician 121/12, the daughter reported resing Services (DNS) that the teangle of condition in 12/15/15/15/15/15/15/15/15/15/15/15/15/15/			TITI F		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		185089		_		05/1	1/2012
	ROVIDER OR SUPPLIER TRANSITIONAL CARE	AND REHABILITATION ROSEW			REET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 000	Resident #1 on 02/17 to the Emergency Ro on 02/21/12. After be incident, the facility in 04/06/12. The facility implemented interver deficiency. Immediat to exist on 02/17/12 the determined the facility corrective action priorinitiating the abbreviar resulting in the determined the facility corrective action priorinitiating the abbreviar resulting in the determined the facility and the determined the facility and the determined the facility resulting in the determined with 483.10(b)(11) NOTIF (INJURY/DECLINE/FACILITY). A facility must immediate consult with the reside known, notify the reside known, as ignificant in health status in either life the clinical complications significantly (i.e., a new existing form of treatment); or a decision of the decisio	om (ER) for an evaluation accoming aware of the ditiated an investigation on a developed and ations to correct the de Jeopardy was determined through 04/28/12. It was a had completed all are to the State Agency ted survey on 05/02/12, thus mination of Past Jeopardy. Stermined to be corrected on the State Agency ted survey on 05/02/12, thus mination of Past Jeopardy. Stermined to be corrected on the Stantiated with no are at a stantiated with no a		157			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		185089	A. BUI B. WIN				C 1/2012
	COVIDER OR SUPPLIER	AND REHABILITATION ROSEW		55	EET ADDRESS, CITY, STATE, ZIP CODE 50 HIGH ST. OWLING GREEN, KY 42101	1 05/1	1/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 157	and, if known, the resor interested family in change in room or rospecified in §483.15 resident rights under regulations as specifithis section. The facility must receive address and pholegal representative of the address and pholegal repr	promptly notify the resident sident's legal representative nember when there is a ommate assignment as (e)(2); or a change in Federal or State law or ied in paragraph (b)(1) of ord and periodically update ne number of the resident's or interested family member. T is not met as evidenced record review, review of the export, and review of the dure, it was determined the alt/notify the resident's exwas a change of condition in the selected sample of exident #1 was admitted to gnosis to include History of exident (CVA) with left-side ered Nurse (RN) #1 was call Therapist Assistant (PTA) if Nurse Aide (SRNA) #1 mange in condition for ident was unable to turn there left side neglect was RN #1 and RN #2 assessed on; however, no changes in	F	157	Past noncompliance: no plan of correction required.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SI COMPLE	
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		185089	B. WING		05/	11/2012
	ROVIDER OR SUPPLIER TRANSITIONAL CAR	E AND REHABILITATION ROSEW	5	REET ADDRESS, CITY, STATE, ZIP CODE 150 HIGH ST. BOWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 157	On 02/17/12 and a resident's daughte in the resident. Sti drawing up to the as well as he/she told RN #5 about the time; however, RN any changes in the On 02/18/12, SRN seemed to be a "3 resident. An asses #3 and an LPN, or changes. On 02/1 RN #3 about the rehowever, there was the physician nor shospital for further On 02/21/12, the redirector of Nursing resident's condition hospital and admit presented with an droop and deviation side. The physicial showed evidence facility failed to proan assessment for Resident #1's chant This failure caused injury, harm, impared The Immediate Je on 02/17/12 through implemented corrections.	again on 02/20/12, the r noticed a marked difference he revealed the resident was left side and not communicating had been. She revealed she he resident's condition at that 1 #5 stated she had not noticed be resident. A #3 revealed that there 60 degree change" in the sement was completed by RN in 02/18/12, with no noted 9/12, SRNA #3 again notified besident's change in condition; is no evidence RN #3 notified been the resident out to the evaluation. Desident's daughter spoke to the graph of services (DNS) about the interest on 02/21/12. The resident acute onset of left-side facial on of his/her eyes to the left on revealed Resident #1 clearly of a stroke on 02/21/12. The poide documented evidence of resigns and symptoms of	F 157			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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	OVIDER OR SUPPLIER	AND REHABILITATION ROSEW		55	EET ADDRESS, CITY, STATE, ZIP CODE 50 HIGH ST. OWLING GREEN, KY 42101	<u> </u>	172012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 157	informed at the time to directly or by pager. A Therapist, on 05/04/1 02/17/12, "It is PT polisee a problem with a A record review reveal Resident #1 on 02/06 include History of Cer (CVA) with left-side history of Gastrointes Renal Failure. A review of the admiss (MDS) assessment, of facility assessed Resilnterview for Mental S (9). The resident was staff for dressing, per He/she required exters for bed mobility, transpassistance with eating A review of a Weekly (OT) Progress Note (I revealed "[resident] diprogression towards of sitting tolerance 30-45 awareness with maximum assistances with assistances with maximum assistances with assistances with assistances with assistances with assistances with assistances with assistance with a wi	y's policy/procedure, a Resident," dated e physician should be he event occurs either an interview with the Physical 2 at 10:30 AM, revealed, on icy, we notify nursing if we resident." aled the facility admitted /12 with diagnoses to rebral Vascular Accident emiparesis on 12/20/11, stinal Bleed and Chronic sion Minimum Data Set lated 02/13/12, revealed the dent #1 to have a Brief status (BIMS) score of nine a totally dependent on one sonal hygiene and bathing. Insive assistance of two staff ofer and toilet use and limited g. - Occupational Therapy PN), dated 02/13/12, emonstrates fair established goals including 5 seconds. Left visual	F	1157			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION 3	(X3) DATE SUR COMPLETE	
		185089	B. WIN	G			C 1/ 2012
	ROVIDER OR SUPPLIER TRANSITIONAL CARE A	AND REHABILITATION ROSEW	l	5	REET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101	G 0, 1	··· -
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 157	noted in tolerance and Rehab Addendum Nou "[resident] noted to hat neglect today and una and tactile cues made Whereas, yesterday, verbal cues. Nursing The document was signer to the personal tactile cues of the color of the c	revealed "improvement d mobility." A review of a PT te, dated 02/17/12, revealed ave more significant left-side able to respond to verbal e from [his/her] left side. [he/she] was able to follow notified of recent changes." gned by the Physical PTA). An interview with the 105/03/12 at 2:00 PM and 1, revealed while she was trapy to Resident #1 on the resident with more d was unable to respond to to follow her past midline, om the previous day. She he resident to the unit and of condition to RN #1. She nurse to assess the stated approximately one d up with RN #1. RN #1 ot see a change of #1. The PTA stated she upervisor of the change of #1. An interview with SRNA 15 PM, revealed when itted to the facility he/she right arm, turn his/her head es. She stated that she and or 02/17/12, noticed the of turn his/her head. "It just ee/she stopped wiggling	F	157			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML	ILTIPLE CONSTRUCTION	(X3) DATE S COMPLE	
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	ROVIDER OR SUPPLIER	AND REHABILITATION ROSEW		STREET ADDRESS, CITY, STATE, ZIP CC 550 HIGH ST. BOWLING GREEN, KY 42101	•	11/2012
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F 157	An interview with RN revealed, on 02/17/1 RN #1 related to Rescondition. RN #1 saichange in Resident # her to assess the resstated, that on 02/17 the PTA had reported resident. She stated reported a change in everything was fine, change in the resident. An interview with the 05/03/12 and 05/07/7 respectively, reveale the 3 PM to 11 PM s 02/20/12, that she had difference in the resident advised RN #5 the recommunicating as we side. She stated the noticed any change at There was no evident regarding the resident documented evidence determined there was resident's condition. An interview with SR and 9:22 AM, revealed and 02/19/12 on the care for Resident #1.	#2, on 05/03/12 at 2:35 PM, 2, that PTA had contacted ident #1's change in d she did not see any and asked me to go with ident on 02/17/12. She was unaware that d a change in condition in the "I just knew someone had the resident. I thought because I did not see a not." Resident #1's daughter, on 12 at 8:25 AM and 11:20 AM, d she reported to RN #5, on nift, on 02/17/12 and and noticed a marked dent. She stated she esident was not ell and drawing up to the left enurse said she had not at all in the resident.	F	157		

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		185089	B. WIN	G			1/2012
	ROVIDER OR SUPPLIER	AND REHABILITATION ROSEW	'	550	ET ADDRESS, CITY, STATE, ZIP CODE HIGH ST. WLING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 157	o2/19/12, the resider did not seem happy degree change." Sh that "the resident see [himself/herself]." Sh assessed the resider stated when she retushe felt perhaps the and his/her condition she notified RN #3 a went in the resident's asked her to stay in resident. She stated she does not die." She stated RN #3 sa [him/her] out." SRN/what she meant by the An interview with RN revealed she did not #1's condition. She report from anyone a resident's condition. There was no evider regarding the resider documented evidence determined there was resident's condition. A review of a Weekly (OT) PN, dated 02/20 demonstrates "sitting one (1) minute. [Resleft neglect during the	ated, on 02/18/12 and It was less eager to help and She stated "it was like a 360 e stated she notified RN #3 emed different and was not he stated RN #3 and an LPN int on 02/18/12. She further irring to work, on 02/19/12, resident had not progressed have a little worse. She said gain and the two of them is room. She stated RN #3 the room and watch the RN #3 stated "God, I hope he stated she asked the goto send the resident out." id, "No, I cannot send A #3 stated "I do not know hat." #3, on 05/03/12 at 4:00 PM, recall a change in Resident stated she did not receive a shout a change in the	F	157			

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		185089	B. WIN	IG		05/11	C 1/ 2012
	ROVIDER OR SUPPLIER TRANSITIONAL CARE A	AND REHABILITATION ROSEW		5	REET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101	00/1	172012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 157	hemiplegia and left not 2/20/12, revealed "n worsening of status in neglect/decreased recontrol and suspicion nursing currently additunderstanding." An interview with the 05/03/12 at 2:00 PM and the Occupational 02/20/12, co-treated was a difficult resident OT to report a change to the nurse on Friday, of more than one person make sure the nurse discipline." An interview with the AM, revealed, prior to cue Resident #1 to at field. She stated, that the resident's left-side severe. "I had to phy resident's head to the notified RN #1 immediated RN #1 advised the resident's daughte understanding of what Later, on 02/20/12, I field Again, the RN advise daughter. She further	eplect." ehab Addendum Note, dated ursing notified of [resident's] including, severe left action, impaired posture of additional CVA with ressing/verbalizing PTA, on 05/02/12 and and 3:05 PM, revealed she Therapist (OT), on Resident #1 because he/she at. She stated she asked the ein the resident's condition e had reported the change to 02/17/12. She revealed, "If in notices a change, I like to knows it is more than one OT, on 05/03/12 at 11:55 or 02/17/12, she was able to tend to his/her left visual to on 02/20/12, she noticed eneglect was much more sically try to move the left." On 02/20/12, she liately of the change of ented that information. She I her that she soul contact	F	157			

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		185089			·		C
	ROVIDER OR SUPPLIER	AND REHABILITATION ROSEW		5	REET ADDRESS, CITY, STATE, ZIP CODE 50 HIGH ST. BOWLING GREEN, KY 42101	<u> 05/1</u>	1/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 157	change in condition." A review of the nurse through 02/20/12, reviphysician was notified condition. The first in in condition for Reside 9:00 AM. A Change "Resident's family state exhibiting signs and stated to a previous food, inability to focus left-sided neglect. Resent to the hospital for physician was made received to send to the rule out CVA." A review of the Magn (MRI) report, complete "Impression: Acute is around the peripheral changes in the distribution of the morning of 02/21, therapy with Resident to the therapy room as a change in Resident daughter she had not 02/17/12. She stated was someone she conshe escorted the daugstated "Resident #1 we Further review of a Pierre side of the days and the peripheral action of the therapy room as a change in Resident daughter she had not 02/17/12. She stated was someone she conshe escorted the days stated "Resident #1 we Further review of a Pierre side of the constant of the province of the stated "Resident #1 we Further review of a Pierre side of the side of the constant of the province of the side of the	l's notes, dated 02/17/12 realed no evidence that the d regarding a change in otation related to a change ent #1 was on 02/21/12 at of Condition Form revealed ites that the resident is symptoms similar to those CVA, such as pocketing s/concentrate and slight equesting the resident be or an evaluation. The aware with a new order he ER for an evaluation to etic Resonance Imaging sed on 02/21/12, revealed schemic changes were seen I area of chronic ischemic nution of the right middle right temporal parietal lobe." PTA, on 05/02/12 and and 3:05 PM, revealed, on 1/12, as she began physical t #1, his/her daughter came and asked if she had noticed #1. She stated she told the	F	157			

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	ROVIDER OR SUPPLIER TRANSITIONAL CARE A	AND REHABILITATION ROSEW	,	55	EET ADDRESS, CITY, STATE, ZIP CODE 50 HIGH ST. OWLING GREEN, KY 42101		
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F 157	of change and decline decreased strength, of decreased sitting bala. An interview with the AM, revealed, on 02/was a change of conditions tated that she and Prelated to his/her abilition balance. She stated notify the nurse about She further stated "I knoted, was not transic aware that OT also not Resident #1 and doct addendum note. An interview with SRI PM, revealed, that on while as she was asseating breakfast, the She stated the daughter at the resident, and I told reported it to my nurse #1 to speak to the dadaughter became upstoned being notified about Find the condition. She stated she spoke to someon change in condition; if daughter revealed, "Name and the condition of the condition," in the condition of the condition of the condition of the condition of the condition. The stated she spoke to someon change in condition; if daughter revealed, "Name and the condition of t	of last week, nursing notified to in status, left-side neglect, decreased mobility and ance." PT, on 05/04/12 at 10:30 17/12, she was aware there dition in Resident #1, iffed her that there had been for Resident #1. She TA discussed the changes ty to follow cues and she advised the PTA to at the change of condition. It was the the change of condition in the change of c	F	157			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SUF	
			A. BUI				С
		185089	B. WIN	G		1	1/2012
	OVIDER OR SUPPLIER	AND REHABILITATION ROSEW	•	550	T ADDRESS, CITY, STATE, ZIP CODE HIGH ST. WLING GREEN, KY 42101		
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F 157	revealed, on 02/21/2 and asked about a cresident. She told modumentation about Resident #1. The dap PTA why she was not PTA told her she did she had done what so notifying the nurse. To the DNS's office. DNS about a noticea 02/17/12, which she stated she informed made her feel like she exaggerating. She so nurse had not made condition. The daughave listened to my dand should have senfor evaluation." A review of the OT D 02/22/12, revealed "I noted regression seen neglect with patient of cervical rotation to 8 midline to left. [Resilateral lean with susptimes one day observable."	It 2 at 8:25 AM and 11:20 AM, she spoke with the PTA hange of condition in the eyes, and there was to a change of condition in hughter stated she asked the or notified. She stated the not know the answer, but she was suppose to do by She stated the PTA took her She stated she spoke to the ble change in the resident on reported to RN #5. She the DNS that the nurse had e was overly concerned or tated the DNS revealed the a report of the change in their stated "the nurse should concerns, listened to the PTA to the resident] to the hospital sischarge Summary, dated fresident] demonstrates condary to increased left demonstrating right lateral degrees, unable to crossident] also with significant left pected worsening of conation wation of therapist."	F	157			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
74451 2744 01	CONNECTION	IDENTIFICATION NO.	A. BUIL	.DING		C	
		185089	B. WING			05/11/2012	
	ROVIDER OR SUPPLIER	AND REHABILITATION ROSEW	,	550 I	T ADDRESS, CITY, STATE, ZIP CODE HIGH ST. VLING GREEN, KY 42101		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 157	A review of a Teachar Form, dated 03/21/12 conducted a teachab the DNS related to incustomer satisfaction employee and the reamoment was related communicates a concommunicate with the resident. If your asseproblem but the famili communicate their content of the family what they was treat in house or send Emergency Room (Esigned by the DNS and A review of a Teachar Form, undated, reveateachable moment was related to accurate do change in condition. employee and the reamoment was related accompanied RN #1 Resident #1 with a reamoment was related accompanied RN #1 Resident #1 with a reamoment was signed by the facility Summary, dated 04/12 Physical Therapist As about a change of coinformed RN #1 the reamoment RN #1 the	ble Moment - Education 2, revealed the facility le moment with RN #1 by aproved communication and 3. The discussion with an ason for a teachable to, "if therapy staff cern with a resident, e family after assessing the essment does not indicate a y is still concerned, ancern to the physician. Ask would like done, whether to d for an evaluation to the R)." The document was and RN #1. ble Moment - Education alted the facility conducted a ith RN #2 by the DNS bocumentation of a resident's The discussion with an ason for a teachable to, "On 02/17/12 you to do an assessment on ported change in condition. it is your responsibility to sment was documented." Igned by the DNS and RN	F	157			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185089	B. WING			C 05/11/2012		
	ROVIDER OR SUPPLIER	E AND REHABILITATION ROSEW	•	550 I	r Address, City, State, Zip Code High St. VLING GREEN, KY 42101	•		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 157	able to track her all PTA stated the resi her in the therapy of asked about any no resident. PTA stated daughter that she rand took the reside office. RN #2 state came to her and ac voiced a concern a regarding Resident assessed Resident changes in his/her admission on 02/06 Resident #1's skin resident's left butto measured 2.8 centiarea had necrotic ti 75% of the wound. foam and a dry dre noticed something and told RN #1 on An interview with R 05/02/12 and 05/03 respectively; howeleave a message. You are attempting at this time." An interview with the PM, revealed she ficoncern with Resid 02/21/12. She state #1's daughter to he "upset about the residence of the state of	the bed and the resident was the way to the window. The dent's daughter approached epartment, on 02/21/12, and officeable changes in the ed that she told the resident's eported a change to nursing int's daughter to the DNS's d, that on 02/17/12, RN #1 vised her that therapy had foot a change in condition #1. RN #2 and RN #1 #1, and did not notice any condition. Upon the resident's interest was a Stage III and meters (cm) by 2.0 cm. The ssue over 50% but less than Treatment was Santyl with essing. SRNA #1 stated she different about Resident #1	F	157				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		С		
		185089	B. WING		05	05/11/2012	
	ROVIDER OR SUPPLIER TRANSITIONAL CAR	RE AND REHABILITATION ROSEW	550	ET ADDRESS, CITY, STATE, ZIP COD HIGH ST. WLING GREEN, KY 42101	E		
(X4) ID PREFIX TAG	(EACH DEFICII	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 157	with his/her prior so looking to the left." daughter went to the resident. The breakfast, and he/mouth. She stated resident sent to the further stated after the hospital, she wasked them, what stated the PTA had condition in Reside the hospital, she wasked them, what stated the PTA had condition in Reside the hospital, she wasked them, what stated the PTA had condition in Reside the hospital, she was observe a change She further stated assessment and help documenting the addressed with RI of condition was reasonable to state of the form, and physician. She further education with completing the SE being an advocate She stated, "It is not report. They are just the family report.	rage 14 Insight resident had exhibited stroke, "pocketing food and "She stated, she and the che resident's room to assess resident had just finished she still had oatmeal in his/her did the daughter wanted the elemergency Room (ER). She is the resident was sent out to event to RN #1 and RN #2 and happened on 02/17/12. They did advised them of a change of ent #1. RN #1 and RN #2 told sessment, and they did not of condition with the resident. They did not document the final no reason for not assessment. She stated she exported, they were to complete round Assessment Request then they were to notify the other stated she did RN #1 and RN #2 related to star, physician notification and the for the resident and family, not at the nurse's discretion not be required to report even if it is corting a change to them." RN #2, on 05/03/12 at 2:35 PM, ent's grip, swallowing ability and the seed. She added that she did ge in the resident's condition. To "make a good nurse's note, ocumented the assessment." The DNS did a Teachable to be sure to follow-up with the	F 157				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		A. BUILDING B. WING		С		
		185089			05/	11/2012
KINDRED	KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW			TREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 157	on 05/03/12 at 10:00 02/21/12, he admitte He stated the resider of left-side facial droceyes to the left side. "clearly showed evid He revealed if a perswe want them sent to stated the MRI, on 00 resident had a stroke **The facility implem correct the deficiency *The resident's physnotified of the reside 02/21/12 and he/she * The facility had an 04/06/12 with IDT to between department service, changes in rnotification of change *An in-service was couly 06/12, to educate Watch form, the 24 hadvocate for the cust a change of condition physician notification *An audit tool was in residents with a char	ian revealed, in an interview, AM, revealed that, on d Resident #1 to the hospital. Interpresented with acute onset op and deviation of his/her He stated the resident ence of a stroke on 02/21/12. Interpresented with acute onset op and deviation of his/her He stated the resident ence of a stroke on 02/21/12. Interpresented the resident ence of a stroke on 02/21/12. Interpretation shows signs of a stroke, Interpretation that the term of the ER right away. He 2/21/12, revealed the Interpretation to the ER. Add Hoc PI meeting held on review communication Is and shifts, customer resident condition and the sin condition. Inconducted for all staff, on them on the Stop and the stop and the staff or with	F 15	57		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1, ,	ILTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185089	A. BUILI		 _ 05	C /11/2012
	NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW			STREET ADDRESS, CITY, STATE, 550 HIGH ST. BOWLING GREEN, KY 42		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 157	*A review of the Terorm for RN #1, day undated, revealed the education by the D *A review of the Adand Agenda form, agenda topics discommunication be customer service, so condition and notification and notification and notification and resident was sign. *A review of inservices, Environmental Services, Environmenta	dated the corrective action as follows: achable Moment Education ted 03/21/12, and RN #2, the two (2) nurses received NS. Hoc PI Meeting Attendance dated 04/06/12, revealed the ussed included: tween departments and shifts, BBAR with reported change in cation on changes in condition. ere DNS, Social Services,	F1	157		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	` '	TIPLE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
			A. BUILD	DING		С	
		185089	B. WING		05/11/2012		
	OVIDER OR SUPPLIER	AND REHABILITATION ROSEW		STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 157	Change of Condition timeline of notification located on all Medica (MAR) books and car computer TL6102-03 a family or resident vion a change in condition be made. Even if we have brought to us, it person voicing the coadvocates for our residence. Therapy, Dietary, Act were inserviced relatively with a condition of a reside via SBAR evaluation evaluation. The discrimination of a reside via SBAR evaluation evaluation. The discrimination of a reside via SBAR evaluation evaluation. The discrimination of a reside via SBAR evaluation evaluation of a reside via SBAR evaluation chan eye read and draining signed by LPN #1 and *A review of a Teach Form, dated 04/23/12 teachable moment from Nursing Services (AD an SBAR evaluation the employee and reamoment was related Stop and Watch form	Tool to determine the in. The Guidelines are tion Administration Record in be pulled from the in. Customer Service "When oice a concern, particularly tion, proper notification must don't see the problem they is a huge problem to the oncern. The staff is to act as ident and families." ivities and Housekeeping and to completing a Stop and employees was compared sign in sheets. All riviced on 04/06/12. able Moment - Education in the staff is to act as ident and families." ivities and Housekeeping and to completing a Stop and employees was compared sign in sheets. All riviced on 04/06/12. able Moment - Education in the staff is to act as ident and families." ivities and Housekeeping and the staff is to act as ident and families." ivities and Housekeeping and the staff is to act as ident and families." ivities and Housekeeping and the staff is to act as ident and families." ivities and	F 1	57			

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
185089 B. WIN				C 05/11/2012	
	s	TREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		1/2012	
CIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE	
th the DNS, on 05/08/12 at 9:35 e facility had a PI meeting on w up on a corrective action plan. dentified was two (2) nurses, RN had missed completing the e stated a teachable moment with es was completed. She stated mplemented a change of ool and had identified all residents be sent out of the facility. She by continued to utilize the change it tool. th RN #7, LPN #2, LPN #3, SRNA RNA #7, Housekeeping staff, and 6/08/12 between 11:14 AM and aled they were inserviced on the form, who to report a change in mpleting the SBAR, assess the he physician, supervisor, ADNS	F 15	57			
30 PM, revealed the facility the change in condition for 02/21/12 and the staff was the resident to the ER. THE CARE/SERVICES FOR THE BEING THE BE	F 30	09			
	IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER: 185089 R ARE AND REHABILITATION ROSEW ARY STATEMENT OF DEFICIENCIES (CIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION) In page 18 F 15 If the DNS, on 05/08/12 at 9:35 to facility had a PI meeting on low up on a corrective action planth dentified was two (2) nurses, RN had missed completing the restated a teachable moment with est was completed. She stated implemented a change of lool and had identified all residents to esent out of the facility. She lay continued to utilize the change it tool. If the RN #7, LPN #2, LPN #3, SRNA RNA #7, Housekeeping staff, and 15/08/12 between 11:14 AM and lailed they were inserviced on the form, who to report a change in mpleting the SBAR, assess the the physician, supervisor, ADNS he assessment. No concerns If the Medical Director, on layer in condition for 02/21/12 and the staff was a lither resident to the ER. If CARE/SERVICES FOR L BEING The state of the physical in the staff was a lither resident to the ER. If CARE/SERVICES FOR L BEING The state of the staff was a lither receive and the facility must researcy care and services to attain highest practicable physical, chosocial well-being, in	R ARE AND REHABILITATION ROSEW ARY STATEMENT OF DEFICIENCIES CICINCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION) In page 18 The the DNS, on 05/08/12 at 9:35 of facility had a PI meeting on we up on a corrective action plan. dentified was two (2) nurses, RN had missed completing the estated a teachable moment with es was completed. She stated mplemented a change of ool and had identified all residents be sent out of the facility. She y continued to utilize the change iit tool. The RNA #7, LPN #2, LPN #3, SRNA RNA RNA #7, Housekeeping staff, and 5/08/12 between 11:14 AM and aled they were inserviced on the form, who to report a change in mpleting the SBAR, assess the the physician, supervisor, ADNS he assessment. No concerns The Medical Director, on 30 PM, revealed the facility ne change in condition for 02/21/12 and the staff was the resident to the ER. The CARE/SERVICES FOR L BEING The stated and the facility must receive and the facility must receive and the facility must researy care and services to attain highest practicable physical, chosocial well-being, in	IDENTIFICATION NUMBER: 185089 R ARE AND REHABILITATION ROSEW RYSTATEMENT OF DEFICIENCIES GIENCY MUST BE PRECEDED BY FULL YYOR LSC IDENTIFYING INFORMATION) In page 18 F 157 The Lord Completed Set and Identified all residents be sent out of the facility. She y continued to utilize the change in tool. the RN #7, LPN #2, LPN #3, SRNA RNA #RN #7, Housekeeping staff, and gibled they were inserviced on the form, who to report a change in mpleting the SBAR, assess the he physician, supervisor, ADNS he assessment. No concerns the the Medical Director, on 30 PM, revealed the facility he assessment. No concerns the the Medical Director, on 20 PM, revealed the facility he send on the resident to the ER. BE CARE/SERVICES FOR L BEING D PROVIDERS, CITY, STATE, ZIP CODE 50 HIGH ST. BOWLING GREEN, KY 42101 D PROVIDERS, CITY, STATE, ZIP CODE 50 HIGH ST. BOWLING GREEN, KY 42101 D PROVIDERS, CITY, STATE, ZIP CODE 50 HIGH ST. BOWLING GREEN, KY 42101 D PROVIDERS, CITY, STATE, ZIP CODE 50 HIGH ST. BOWLING GREEN, KY 42101 D PROVIDERS, CITY, STATE, ZIP CODE 50 HIGH ST. BOWLING GREEN, KY 42101 D PROVIDERS, CITY, STATE, ZIP CODE 50 HIGH ST. BOWLING GREEN, KY 42101 D PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 157 F 15	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
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		185089	B. WING _		05/11/2012	
	ROVIDER OR SUPPLIER TRANSITIONAL CAR	E AND REHABILITATION ROSEW		REET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
F 309	Continued From pa and plan of care.	age 19	F 309			
	by: Based on interview facility's policy/prod facility's Investigati the facility failed to and services to atta practicable physical the comprehensive (#1), in the selecte residents. The face "Condition Change procedure. Resident #1 was a diagnosis to include Accident (CVA) with 02/17/12, Physical State Registered N. Resident's daughter a noticeable change. The resident's left is he/she was unable 02/18/12 and 02/18 nurse that there see change" in the resident's] worsen left neglect/decreas control and suspicinursing currently a understanding." The evidence that facili	NT is not met as evidenced In the sedure, and review, review of the sedure, and review of the ve Report, it was determined provide the necessary care ain or maintain the highest all well-being in accordance with a sassessment for one resident disample of three (3) dility failed to follow their of a Resident" policy and Individual to the facility with a see History of Cerebral Vascular high left-side hemiparesis. On Therapist Assistant (PTA), three Aide (SRNA) #1 and the ser notified facility nurses about see in condition for Resident #1. Side neglect was worse and to turn his/her head. On 10/12, SRNA #3 notified a facility semed to be a "360 degree dent. On 02/20/12, the apist (OT) notified nursing "of ing of status including, severe sed reaction, impaired posture on of additional CVA with didressing/verbalizing here was no documented ty nurses assessed Resident condition, communicated the		Past noncompliance: no plan of correction required.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185089	B. WIN	G			C 1/2012
	OVIDER OR SUPPLIER	AND REHABILITATION ROSEW		550	ET ADDRESS, CITY, STATE, ZIP CODE O HIGH ST. OWLING GREEN, KY 42101	1 00/1	172012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	notified the physician change in Resident # resident's daughter s Nursing Services (DN sent out and admitted presented with an action and deviation of side. The physician is showed evidence of facility failed to provid an assessment for sichange in condition for the side of the sid	oncoming shift nurses or of the multiple reports of a string of the hospital. He/she ute onset of left-side facial of his/her eyes to the left revealed Resident #1 clearly a stroke on 02/21/12. The de documented evidence of gns and symptoms of a for Resident #1. The silikely to cause serious ent, or death to a resident. and was determined to exist 04/28/12. The facility we action which was a State Agency's was determined Past Dy's policy/procedure, for a Resident, "dated is the responsibility of the sess resident, take vital inperature, gather and	F	309			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUII	DING	<u></u>	С	
185089		185089	B. WING			05/11/2012	
	ROVIDER OR SUPPLIER	AND REHABILITATION ROSEW		550	T ADDRESS, CITY, STATE, ZIP CODE HIGH ST. WLING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 309	A record review reveal Resident #1 on 02/06 include History of Cerecord (CVA) with left-side in History of Gastrointes Renal Failure. A review Minimum Data Set (Mo2/13/12, revealed th #1 to have a Brief Into (BIMS) score of nine dependent on one standard toilet use and limit A review of a Weekly (OT) Progress Note (revealed "[resident] of progression towards sitting tolerance 30-4 awareness with maxifor a Physical Therapy dated 02/14/12, revealed "Interview of a PT Reho 02/17/12, revealed "Int	aled the facility admitted 6/12 with diagnoses to rebral Vascular Accident emiparesis on 12/20/11, stinal Bleed and Chronic ew of the admission MDS) assessment, dated e facility assessed Resident erview for Mental Status (9). The resident was totally aff for dressing, personal He/she required extensive ff for bed mobility, transfer lited assistance with eating. - Occupational Therapy PN), dated 02/13/12, demonstrates fair established goals including 5 seconds. Left visual mum verbal cues." A review of (PT) Progress Note (PN), aled "improvement noted in	F	309			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			С
		185089	B. WING		05/11/2012	
	ROVIDER OR SUPPLIER TRANSITIONAL CAF	RE AND REHABILITATION ROSEW	550 I	T ADDRESS, CITY, STATE, ZIP COD HIGH ST. VLING GREEN, KY 42101	E	
(X4) ID PREFIX TAG	(EACH DEFICII	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 309	respond to verbal midline, which was day. She stated she unit and reported with resident. She one hour later she will told her that she condition in Residualso notified her Production in Residualso notified his/her to move and wiggle his/her to move and wiggle his/her toes and findifference." We rechange of condition that Resident was rinterview with the revealed, on 02/13 a change of condition that she and Production that she are the production that she are t	and neglect, and was unable to tactile cues or to follow her past is different from the previous he returned the resident to the the change of condition to RN is asked the nurse to assess further stated approximately if followed up with RN #1. RN is edid not see a change of ent #1. The PTA stated she if it is the change of ent #1. An interview with SRNA is 2:35 PM, revealed when admitted to the facility he/she the right arm, turn his/her head into the stated that she and is to she stated that she and is to she stated that was a notified RN #1 regarding the into the she stated RN #1 told them had a stroke, and this was why at. She stated she told RN #1 not like that a few days ago. An PT, on 05/04/12 at 10:30 AM, 7/12, she was aware there was the tion in Resident #1, because er that there had been a in for Resident #1. She stated discussed the changes related in follow cues and balance. She is discussed the PTA to notify the nurse	F 309			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	JLTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUIL	DING		С	
		185089	B. WING	G	. 05/	/11/2012	
	ROVIDER OR SUPPLIER TRANSITIONAL CARE	AND REHABILITATION ROSEW		STREET ADDRESS, CITY, STATE, Z 550 HIGH ST. BOWLING GREEN, KY 421	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE	
F 309	change in Resident and her to assess the resistated, that on 02/17 the PTA had reporteresident. She stated reported a change in everything was fine, change in the reside. An interview with the 05/03/12 and 05/07/respectively, revealed the 3 PM to 11 PM society 02/20/12, that she had difference in the resistadvised RN #5 the recommunicating as with side. She stated the noticed any change and occumented evide conducted an assess was a significant charcondition on 02/17/1. An interview with SR and 9:22 AM, revealed and 02/19/12 on the care for Resident #1 prior to 02/18/12, had with toileting. She stocked did not seem happy, degree change." She	d she did not see any #1 and asked me to go with sident on 02/17/12. She /12, she was not aware that d a change of condition in the "I just knew someone had the resident. I thought because I did not see a nt." Resident #1's daughter, on 12 at 8:25 AM and 11:20 AM, d she reported to RN #5, on hift, on 02/17/12 and ad noticed a marked dent. She stated she esident was not ell and drawing up to the left e nurse said she had not at all in the resident. Ince facility staff notified the other esident's condition and ence that the nursing staff sment to determine if there inge in the resident's	F	309			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		405000	B. WIN	LDING IG			С	
	ROVIDER OR SUPPLIER TRANSITIONAL CARE	185089 AND REHABILITATION ROSEW		STREE	T ADDRESS, CITY, STATE, ZIP CODE HIGH ST. VLING GREEN, KY 42101	05/1	1/2012	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 309	[himself/herself]." Si assessed the resider stated when she retushe felt perhaps the and his/her conditionshe notified RN #3 a went in the resident's asked her to stay in resident. She stated she does not die." Si nurse "was she going She stated RN #3 sa [him/her] out." SRN/what she meant by the stated she had no condition in Resident get a report from any change in the reside. There was no evider physician regarding in the documented evid conducted an assess was a significant charcondition on 02/18/1. A review of a Weekly (OT) PN, dated 02/2 demonstrates "sitting one (1) minute. [Resident plegical proposed plance as the miplegia and left in the review of the OT Fill assessment of the other states are sitting one (1) minute. [Resident plegical plegical proposed plance as the miplegial and left in the review of the OT Fill assessment of the other states are sitting one (1) minute. [Resident plegical	the stated RN #3 and an LPN and ton 02/18/12. She further strined to work, on 02/19/12, resident had not progressed a was a little worse. She said gain and the two of them a room. She stated RN #3 the room and watch the RN #3 stated "God, I hope the stated she asked the goto send the resident out." idid, "No, I cannot send A #3 stated "I do not know that." I #3, on 05/03/12 at 4:00 PM, recollection of a change in the stated she did not a staff or nurses about a not's condition. Ince facility staff notified the the resident's condition and the ence that the nursing staff the sment to determine if there are in the resident's 2 or 02/19/12. I *Occupational Therapy 0/12, revealed [resident] to the total presents with severe the erapy, decreased positioning, and decreased strength, left	F	309				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUI				С
		185089	B. WIN			05/1	11/2012
	ROVIDER OR SUPPLIER TRANSITIONAL CARE	AND REHABILITATION ROSEW		550 I	T ADDRESS, CITY, STATE, ZIP CODE HIGH ST. VLING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	worsening of status neglect/decreased recontrol and suspicionursing currently adunderstanding." An interview with the 05/03/12 at 2:00 PM and the Occupationa 02/20/12, were co-treated the OT to repthe here was a difficult asked the OT to repthe nurse since she the nurse on Friday, more than one personake sure the nurse discipline." An interview with the AM, revealed, prior to cue Resident #1 to a field. She stated, the the resident's left-sic severe. "I had to phresident's head to the notified RN #1 immedendition on 02/20/1 nursing was notified her that she would overbalized understant to her. Later, on 02/#1. She again adviscontact the daughter expected the nurse of and report the change. An interview with RN and the control of the change and report the change.	including, severe left eaction, impaired posture n of additional CVA with dressing/verbalizing e PTA, on 05/02/12 and and 3:05 PM, revealed she al Therapist (OT), on eating Resident #1 because t resident. She stated she ort a change of condition to had reported the change to 02/17/12. She stated, "If on notices a change, I like to e knows it is more than one e OT, on 05/03/12 at 11:55 to 02/17/12, she was able to attend to his/her left visual at on 02/20/12, she noticed de neglect was much more sysically try to move the e left." She said she ediately of the change of 2 and documented that . She stated RN #1 advised ontact the daughter. She inding of what I was reporting 20/12, I followed up with RN and me she was going to r. She further stated "I would contact the physician	F	309			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPL _DING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185089	B. WIN	G			C 1/2012	
	ROVIDER OR SUPPLIER TRANSITIONAL CARE A	AND REHABILITATION ROSEW	•	55	EET ADDRESS, CITY, STATE, ZIP CODE 0 HIGH ST. DWLING GREEN, KY 42101		-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 309	did not notice a change condition. She stated a good nurse's note, documented the assenurse's notes, dated or revealed no evidence for Resident #1 or the a change in condition	If speech. She stated she ge in the resident's at she asked RN #1 to "make but neither of us essment." A review of the 02/17/12 through 02/20/12, of a nursing assessment at the physician was noted of .	F	309				
	PM, revealed, that on while she was assisting breakfast, the resider stated the daughter of pocketing food worse asked if I had noticed and I told her yes, annurse. SRNA #1 asked daughter. She stated with RN #1 about not Resident #1's change RN #1 told the daughter. The daughter. The daughter. The daughter. The daughter and interview with 05/03/12 at 2:00 PM at the morning of 02/21/therapy with Resident to the therapy room at a change in Resident daughter she had not 02/17/12. She stated was someone she coshe escorted the daustated "Resident #1 we Further review of a Pi	e in condition. She stated ter she had talked to her stated "No one talked to the herth, on 05/02/12 and and 3:05 PM, revealed, on 12, as she began physical t #1, his/her daughter came and asked if she had noticed #1. She stated she told the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185089	B. WIN		·		C 1/2012	
	ROVIDER OR SUPPLIER TRANSITIONAL CARE A	AND REHABILITATION ROSEW	<u> </u>	5	REET ADDRESS, CITY, STATE, ZIP CODE 50 HIGH ST. BOWLING GREEN, KY 42101		1/2012	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 309	of change and decline decreased strength, of decreased sitting bala PT, on 05/04/12 at 10 02/17/12, she was aw condition in Resident know that the change transient." She stated also noted a change of and documented the note. An interview with the 05/03/12 and 05/07/1 revealed she spoke where and asked her if she is resident. She told me documented there was Resident #1. The date PTA why no one had PTA told her she did notified, but she had to do by notifying the took her to the DNS's she advised the DNS change in the resident had reported the charshe informed the DNS her feel like she was exaggerating. She sthad not made a report The daughter stated listened to my concershould have sent [the evaluation."	of last week, nursing notified to in status, left-side neglect, decreased mobility and ance." An interview with the 0:30 AM, revealed, on ware there was a change of #1, and further stated "I was not do she was aware that OT of condition in Resident #1 same in her addendum Resident #1's daughter, on 2 at 8:25 AM and 11:20 AM, with the PTA on 02/21/12, and noticed a change in the eyes, and she had as a change of condition in aughter stated she asked the notified her. She stated the not know why I was not done what she was suppose nurse. She stated the PTA office. She further stated that she had noticed a at on 02/17/12, and that she nige to RN #5. She stated She at the nurse had made	F	309				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF	
		185089	B. WIN	IG	·		0
	ROVIDER OR SUPPLIER	AND REHABILITATION ROSEW		5	REET ADDRESS, CITY, STATE, ZIP CODE 150 HIGH ST. 30WLING GREEN, KY 42101	05/1	1/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	for Resident #1 in the 02/21/12 at 9:00 AM. Form revealed "Resident is exhibiting to those related to a pocketing food, inabil slight left-sided negle be sent to the hospita physician was made received to send to the rule out CVA." A review of the Magn (MRI) report, complet "Impression: Acute is around the peripheral changes in the distribution of the OT D 02/22/12, revealed "[In noted regression secone glect with patient docervical rotation to 80 midline to left. [Residulateral lean with suspitimes one day observation of the PT Di 02/22/12, revealed "to however, overall to do the recent decline. Rechange in medical sthospitalization." A review of a Teachar Form, dated 03/21/12	e medical record was on A Change of Condition dent's family states that the signs and symptoms similar previous CVA, such as ity to focus/concentrate and act. Requesting the resident al for an evaluation. The aware with a new order the ER for an evaluation to etic Resonance Imaging ted on 02/21/12, revealed schemic changes were seen I area of chronic ischemic fution of the right middle right temporal parietal lobe." ischarge Summary, dated resident] demonstrates ondary to increased left temonstrating right lateral of degrees, unable to cross dent] also with significant left tected worsening of conation vation of therapist." scharge Summary, dated reatment initially successful; ate no progress related to teason for Discharge:	F	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUI	LDING		. C	
		185089	B. WIN	IG			1/2012
	ROVIDER OR SUPPLIER	AND REHABILITATION ROSEW	•	55	EET ADDRESS, CITY, STATE, ZIP CODE 10 HIGH ST. OWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	the DNS related to imcustomer satisfaction employee and the reamoment was related communicates a concommunicate with the resident. If your asseproblem but the familicommunicate their content in house or send Emergency Room (Esigned by the DNS and A review of a Teachar Form, undated, reveateachable moment wirelated to accurate do change in condition. employee and the reamoment was related accompanied RN #1 Resident #1 with a react As the Unit Manager, make sure the assess The document was simple. A review of the facility Summary, dated 04/17 Physical Therapist As that she noticed a characteristic accommunity and left side neglect was with the PTA and adviresident was lying on and the resident was	proved communication and The discussion with an ason for a teachable to, "if therapy staff therapy staff therapy staff therapy after assessing the assessing	F	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND I LAN OI	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDIN	<u> </u>	COMILE	
		185089	B. WING		05/	C 11/2012
	OVIDER OR SUPPLIER	AND REHABILITATION ROSEW		REET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101	_	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	department, on 02/2 had noticed any chastated that she told she reported a charresident's daughter stated, that on 02/1 advised her that the about a change in compartment of the about a change in cha	ed her in the therapy 21/12, and asked her if she anges in the resident. PTA the resident's daughter that age to nursing and took the to the DNS's office. RN #2 7/12, RN #1 came to her and arapy had voiced a concern ondition regarding Resident anied RN #1 to assess did not notice any changes in the type of the wound. The type of the wound area had necrotic tissue and 75% of the wound. The with the DON, on the resident's her downwith the DON, on the resident's chart and the resident's chart are sore and the resident are sore are sore and the r	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	 ` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING	<u> </u>		С
		185089	B. WING			1/2012
	ROVIDER OR SUPPLIER	E AND REHABILITATION ROSEW	5	EET ADDRESS, CITY, STATE, ZIP CODE 50 HIGH ST. BOWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	PM, revealed she froncern with Reside 02/21/12. She stat #1's daughter to he "upset about the rethe daughter told he same symptom with his/her prior st looking to the left." daughter went to the the resident. The resident. The resident sent to the further stated after the hospital, she wasked them, what he stated the PTA had condition in Reside me they did an assobserve a change of She further stated assessment and he documenting the asaddressed with RN of condition was rea Situation Backgro (SBAR) form, and the physician. She further education with Roman and selection with RN of condition was real situation Backgro (SBAR) form, and the physician. She further stated, "It is not oreport. They are	ne DNS, on 05/02/12 at 2:55 irst became aware of a lent #1 on the morning of led the PTA brought Resident er office because she was sident's condition." She stated er she was noticing some of les the resident had exhibited roke, "pocketing food and She stated, she and the line resident's room to assess resident had just finished she still had oatmeal in his/her the daughter wanted the le Emergency Room (ER). She the resident was sent out to lent to RN #1 and RN #2 and lappened on 02/17/12. They ladvised them of a change of lent #1. RN #1 and RN #2 told lessment, and they did not lof condition with the resident. It was a change left and RN #2 when a change left and Assessment Request left and Roy were to complete left and Assessment Request left and Roy were to notify the	F 309			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185089	B. WIN				C 1/2012
	OVIDER OR SUPPLIER	AND REHABILITATION ROSEW		55	EET ADDRESS, CITY, STATE, ZIP CODE 50 HIGH ST. OWLING GREEN, KY 42101	1 55/1	1/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	05/03/12 at 10:00 AN Resident #1 to the hostated he/she present left-side facial droop to the left side. He showed evidence of stated if a person showant them sent to the MRI on 02/21/12 stroke. **The facility implement correct the deficiency of the resident service, changes in resident of change of the cust a change of condition of the cust a change of condition of the residents with a chart tool is ongoing on residents with a chart tool is ongoing on residents.	sident #1's physician, on In revealed that he admitted ospital on 02/21/12. He of the with acute onset of and deviation of his/her eyes tated Resident #1 "clearly a stroke on 02/21/12. He ows signs of a stroke, we as ER right away. He stated revealed the resident had a mented the following actions to In cian/medical director was ont's change in condition on was sent to the ER. Ad Hoc PI meeting held on review communication and shifts, customer esident condition and es in condition. Conducted for all staff, on them on the Stop and our report book, being an comers, the SBAR form with	F	309			

1, 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185089	B. WIN				C
	COVIDER OR SUPPLIER	AND REHABILITATION ROSEW		5	REET ADDRESS, CITY, STATE, ZIP CODE 150 HIGH ST. BOWLING GREEN, KY 42101	<u> </u>	1/2012
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		1	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		LD BE	(X5) COMPLETION DATE
F 309	*A review of the Teach Form for RN #1, date undated, revealed the education by the DNS *A review of the Ad Hand Agenda form, da agenda topics discuss Communication betwo customer service, SE condition and notifica The staff present wer Nutrition Services, Ac Environmental Service document was signed *A review of inservice all staff were educated Condition and Stop at a change of condition Stop and Watch Form to the Charge Nurse Documentation of Resultant Whenever a change resident, the SBAR Form before the physician form is to be placed in changes in condition hour report book to promote for follow up." Guide Notification of Change of Condition timeline of notification timeline timeline timeline timeline timelin	chable Moment Education d 03/21/12, and RN #2, etwo (2) nurses received S. Ioc PI Meeting Attendance ted 04/06/12, revealed the sed included: een departments and shifts, EAR with reported change in tion on changes in condition. The DNS, Social Services, ctivities Director, tes and Licensed nurse. The d by all staff present. Les, dated 04/06/12, revealed ed on Resident Change in and Watch Form "Whenever in its identified in a resident, a in its to be filled ou and given before the end of the shift." Is identified. The completed in the progress notes. All must be written on the 24 ass on to the oncoming shift	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		185089	B. WIN	G			C 1/ 2012
	ROVIDER OR SUPPLIER TRANSITIONAL CARE A	AND REHABILITATION ROSEW		5	REET ADDRESS, CITY, STATE, ZIP CODE 50 HIGH ST. BOWLING GREEN, KY 42101	00/1	172012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 309	a family or resident voon a change in condit be made. Even if we have brought to us, it person voicing the co advocates for our res Therapy, Dietary, Act were inserviced relate Watch form. A list of against the inservice employees were inse *A review of a Teacha Form, dated 04/18/12 a teachable moment evaluation of a reside via SBAR evaluation evaluation. The discuand reason for the teato, "failed to complete with a condition change eye read and draining signed by LPN #1 and *A review of a Teacha Form, dated 04/23/12 teachable moment fron Nursing Services (AD an SBAR evaluation of the employee and reamoment was related to Stop and Watch form out. The document was ADNS.	be pulled from the " Customer Service "When bice a concern, particularly ion, proper notification must don't see the problem they is a huge problem to the ncern. The staff is to act as ident and families." ivities and Housekeeping ad to completing a Stop and employees was compared sign in sheets. All rviced on 04/06/12. Table Moment - Education of the related to note the rough is in condition form, complete thorough is in sheets and the moment was related as SBAR assessment tool ge of Resident 150 B left of the document was in the Assistant Director of the problem is in the Assistant Director of the problem is in the Assistant Director of the problem is in the discussion with	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
							С
		185089	D. WIIN	<u> </u>		05/1	1/2012
	OVIDER OR SUPPLIER TRANSITIONAL CARE A	AND REHABILITATION ROSEW		5	REET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 309	AM, revealed the faci 04/27/12 to follow up The only issue identif #7 and LPN #1, had r SBAR form. She stat the two (2) nurses was the facility had impler condition audit tool are that needed to be ser stated the facility comof condition audit tool are that needed to be ser stated the facility comof condition audit tool are that needed to be ser stated the facility comof condition audit tool *An interview with RN #5, SRNA #6, SRNA COTA #2, on 05/08/112:40 PM, revealed the stop and watch form, condition to, completing resident, notify the phand document the aswere identified. *An interview with the 05/03/12 at 12:30 PM notified him of the characteristic to send the resident #1 on 02/21 directed to send the resident #1 on 02/21 directed to send the resident #1 on one of the characteristic to send the resident #1 on one of the characteristic to send the resident #1 on one of the characteristic to send the resident #1 on one of the characteristic to send the resident #1 on one of the characteristic to send the resident #1 on one of the characteristic that the facility must main resident in accordance.	lity had a PI meeting on on a corrective action plan. ied was two (2) nurses, RN missed completing the red a teachable moment with as completed. She stated mented a change of and had identified all residents at out of the facility. She tinued to utilize the change of the facility of the state of the facility. She tinued to utilize the change of the facility of the facility. She tinued to utilize the change of the facility of t		514			

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILT			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185089	B. WIN	G			C 1/2012
	ROVIDER OR SUPPLIER TRANSITIONAL CARE A	AND REHABILITATION ROSEW	,	5	EET ADDRESS, CITY, STATE, ZIP CODE 50 HIGH ST. COWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 514	resident's assessmer services provided; the preadmission screeni and progress notes.	the resident; a record of the ots; the plan of care and e results of any ng conducted by the State;	F	514			
	by: Based on interview, the facility's policy/prote facility failed to morelated to accurately due to a change in coin the selected sample	record review, and review of ocedure, it was determined aintain a clinical record documenting an assessment andition for one resident (#1), e of three (3) residents. The their "Condition Change of d procedure.			Past noncompliance: no plan of correction required.		
	diagnosis to include haccident (CVA) with I 02/17/12, Physical Tr State Registered Num Resident's daughter ranoticeable change in The resident's left sid he/she was unable to 02/18/12 and 02/19/1 nurse that there seen change" in the reside Occupational Therapi [resident's] worsening left neglect/decreased control and suspicion nursing currently add understanding." The evidence that facility	ist (OT) notified nursing "of g of status including, severe d reaction, impaired posture of additional CVA with					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185089	B. WIN	IG		C 05/11/2012	
	ROVIDER OR SUPPLIER	AND REHABILITATION ROSEW		550	ET ADDRESS, CITY, STATE, ZIP CODE) HIGH ST.)WLING GREEN, KY 42101		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 514	notified the physician change in Resident # resident's daughter s Nursing Services (DN sent out and admitted presented with an ac droop and deviation of side. The physician is showed evidence of a facility failed to provid an assessment for significant concerns related to the This failure caused of injury, harm, impairm The Immediate Jeopa on 02/17/12 through implemented correctic completed prior to the investigation, thus it is Jeopardy. This failure caused of injury, harm, impairm The Immediate Jeopa on 02/17/12 through implemented correctic completed prior to the investigation, thus it is Jeopardy. (Refer to be Findings include:	oncoming shift nurses or of the multiple reports of a st. On 02/21/12, the poke with the Director of als). The resident was was at to the hospital. He/she ute onset of left-side facial of his/her eyes to the left revealed Resident #1 clearly a stroke on 02/21/12. The de documented evidence of gns and symptoms of a or Resident # 1 after multiple by notified nursing of the changes in Resident #1. It is likely to cause serious ent, or death to a resident. and was determined to exist 04/28/12. The facility we action which was the State Agency's was determined to exist 04/28/12. The facility was determined to exist 04/28/12. The facility was determined Past estate Agency's was determined Past	F	514			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIDENTIFICATION NUMBER: A. BUILDI			E CONSTRUCTION	(X3) DATE SUF COMPLETI	
		185089	B. WIN	IG			C 1/2012
	ROVIDER OR SUPPLIER	AND REHABILITATION ROSEW		550	ET ADDRESS, CITY, STATE, ZIP CODE D HIGH ST. DWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 514	resident, take vital signather and organize (chart, medication list physician notification resident's condition a until stable." An inter Therapist (PT), on 05 revealed "It is PT pol see a problem with a The facility admitted diagnoses to include Accident (CVA) with 12/20/11, History of Chronic Renal Failure Minimum Data Set (NO2/13/12, revealed the H1 to have a Brief Int (BIMS) score of nine dependent on one stranger and bathing assistance of two states and toilet use and lim A Weekly - Occupation Note (PN), dated O2/demonstrates fair profestablished goals inconseconds. Left visual verbal cues." A review (PT) Progress Note (revealed "improvement mobility."	censed nurse to "assess gns and include temperature, the resident information to vital signs, etc.) for monitor and reassess and response to interventions view with the Physical Mod/12 at 10:30 AM, icy, we notify nursing if we resident." Resident #1 on 02/06/12 with History of Cerebral Vascular eft-side hemiparesis on Gastrointestinal Bleed and e. A review of the admission MDS) assessment, dated e facility assessed Resident erview for Mental Status (9). The resident was totally aff for dressing, personal He/she required extensive ff for bed mobility, transfer inted assistance with eating. In the sident "[resident] resident] regression towards luding sitting tolerance 30-45 awareness with maximum to one of the property of t	F	514			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185089	A. BUILDING B. WING		C 05/11/2012	
	ROVIDER OR SUPPLIER TRANSITIONAL CARE	AND REHABILITATION ROSEW	550 1	T ADDRESS, CITY, STATE, ZIP CODE HIGH ST. VLING GREEN, KY 42101	05/11/2012	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETI	
F 514	[his/her] left side. We was able to follow verification of the physical The 05/02/12 and 05/03. The objectively, an interview with more left-sided respond to verbal tamidline, which was day. She stated shount and reported the #1. She stated shount and reported the #1. She stated shount and reported the resident. She function in Resider also notified her PT condition in Resider #1, on 05/02/12 at 2 Resident #1 was adwas able to move the and wiggle his/her to the PTA, on 02/16/1 resident was unable stayed to the side. his/her toes and find difference." We not change of condition that Resident #1 has he/she was like that the resident was not interview with the Prevealed, on 02/17/1 a change of condition that Resident was not interview with the Prevealed, on 02/17/1 a change of condition that Resident was not interview with the Prevealed, on 02/17/1 a change of condition that Resident was not interview with the Prevealed, on 02/17/1 a change of condition that Resident was not interview with the Prevealed, on 02/17/1 a change of condition that Resident was not interview with the Prevealed, on 02/17/1 a change of condition that Resident was not interview with the Prevealed, on 02/17/1 a change of condition that Resident was not interview with the Prevealed, on 02/17/1 a change of condition that Resident was not interview with the Prevealed, on 02/17/1 a change of condition that Resident was not interview with the Prevealed, on 02/17/1 a change of condition that Resident was not interview with the Prevealed, on 02/17/1 a change of condition that Resident was not interview with the Prevealed, on 02/17/1 a change of condition that Resident was not interview with the Prevealed, on 02/17/1 a change of condition that Resident was not interview with the Prevealed, on 02/17/1 a change of condition that Resident was not interview with the Prevealed, on 02/17/1 a change of condition that Resident was not interview with the Prevealed, on 02/17/1 a change of condition that Resident was not interview with the Prevealed, on 02/17/	and tactile cues made from whereas, yesterday, [he/she] erbal cues. Nursing notified The document was signed rapist Assistant (PTA). On (12 at 2:00 PM and 3:05 PM, erview with the PTA, revealed ding physical therapy to 17/12, she noticed the resident neglect, and was unable to inctile cues or to follow her past different from the previous ereturned the resident to the echange of condition to RN asked the nurse to assess unther stated approximately collowed up with RN #1. RN did not see a change of at #1. The PTA stated she supervisor of the change of the thange of the t	F 514			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185089	B. WING		05	C / 11/2012	
	ROVIDER OR SUPPLIER TRANSITIONAL CAR	E AND REHABILITATION ROSEW	55	EET ADDRESS, CITY, STATE, ZIP CODE 10 HIGH ST. OWLING GREEN, KY 42101	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 514	that she and PTA of to his/her ability to stated she advised about the change of the provided about the change of the provided and the provide	in for Resident #1. She stated discussed the changes related follow cues and balance. She the PTA to notify the nurse of condition. IN #2, on 05/03/12 at 2:35 PM, on 02/17/12, had contacted esident #1's change in aid she did not see any that and asked me to go with esident on 02/17/12. She in the resident on 02/17/12. She in the resident. I thought the pecause I did not see a ent." In eresident #1's daughter, on in the end in the resident. I thought the pecause I did not see a ent." In eresident #1's daughter, on in the end in the resident was not in the resident. She stated she in the resident was not well and drawing up to the left the nurse said she had not ent at all in the resident. In eresident was not well and drawing up to the left the nurse said she had not ent at all in the resident. In eresident was not well and drawing up to the left the nurse said she had not ent at all in the resident.	F 514				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185089	A. BUILDING B. WING		05	C
	ROVIDER OR SUPPLIER TRANSITIONAL CARE	AND REHABILITATION ROSEW	550	ET ADDRESS, CITY, STATE, ZIP CODE HIGH ST. WLING GREEN, KY 42101		11/2012
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514	prior to 02/18/12, ha with toileting. She s 02/19/12, the reside did not seem happy degree change." She that "the resident see [himself/herself]." Sassessed the reside stated when she retishe felt perhaps the and his/her condition she notified RN #3 awent in the resident asked her to stay in resident. She stated she does not die." Sonurse "was she goir She stated RN #3 signim/her] out." SRN what she meant by the condition in Resider get a report from an change in the resident There was no docur nursing staff conductermine if there we resident's condition The Weekly - Occup dated 02/20/12, reversitting tolerance 45 [Resident] presents	She stated the resident, d wanted to get up and help tated, on 02/18/12 and nt was less eager to help and She stated "it was like a 360 the stated she notified RN #3 the stated RN #3 and an LPN int on 02/18/12. She further turned to work, on 02/19/12, resident had not progressed in was a little worse. She said togain and the two of them is room. She stated RN #3 the room and watch the id RN #3 stated "God, I hope is she stated she asked the g to send the resident out." aid, "No, I cannot send A #3 stated "I do not know hat." I #3, on 05/03/12 at 4:00 PM, or recollection of a change in the stated she did not y staff or nurses about a	F 514			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUI				C
		185089	D. WIIV			05/1	1/2012
	OVIDER OR SUPPLIER TRANSITIONAL CARE	AND REHABILITATION ROSEW		55	EET ADDRESS, CITY, STATE, ZIP CODE 0 HIGH ST. DWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 514	Continued From pag	e 42	F	514			
	balance and decreas and left neglect."	sed strength, left hemiplegia					
	revealed "nursing no worsening of status i neglect/decreased re	including, severe left eaction, impaired posture n of additional CVA with					
	PMAn interview with the Occupational The were co-treating Res was a difficult reside OT to report a chang since she had report on Friday, 02/17/12. one person notices a	the PTA revealed she and erapist (OT), on 02/20/12, sident #1 because he/she nt. She stated she asked the ge of condition to the nurse ed the change to the nurse She stated, "If more than a change, I like to make sure more than one discipline."					
	AM, revealed, prior to cue Resident #1 to a field. She stated, that the resident's left-sid severe. "I had to phy resident's head to the notified RN #1 imme condition on 02/20/1. nursing was notified, her that she would coverbalized understar to her. Later, on 02/#1. She again advis contact the daughter	e OT, on 05/03/12 at 11:55 o 02/17/12, she was able to attend to his/her left visual at on 02/20/12, she noticed le neglect was much more ysically try to move the e left." She said she diately of the change of 2 and documented that She stated RN #1 advised ontact the daughter. She nding of what I was reporting 20/12, I followed up with RN ed me she was going to She further stated "I would contact the physician					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SUR COMPLETE	ED
		185089	B. WIN	G			C 1/2012
	ROVIDER OR SUPPLIER	AND REHABILITATION ROSEW		55	EET ADDRESS, CITY, STATE, ZIP CODE 0 HIGH ST. DWLING GREEN, KY 42101		172012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 514	and report the change An interview with RN revealed they assess swallowing ability and did not notice a chancondition. She state a good nurse's note, documented the assumurse's notes, dated revealed no evidence for Resident #1 or that a change in condition. An interview with SR PM, revealed, that or while she was assist breakfast, the reside stated the daughter of "pocketing food wors asked if I had notice and I told her yes, ar nurse. SRNA #1 ask daughter. She state with RN #1 about no Resident #1's change RN #1 told the daugh someone. The daugh me." An interview wo 05/03/12 at 2:00 PM the morning of 02/21 therapy with Resider to the therapy room a change in Residen daughter she had no 02/17/12. She states	#2, on 05/03/12 at 2:35 PM, sed the resident's grip, d speech. She stated she ge in the resident's d she asked RN #1 to "make but neither of us essment." A review of the 02/17/12 through 02/20/12, e of a nursing assessment at the physician was noted of n. NA #1, on 05/02/12 at 2:35 in the morning of 02/21/12, fing the resident with eating int's daughter came in. She commented the resident was e." She stated the daughter d a change in the resident, and I had reported it to my sed RN #1 to speak to the did the daughter became upset to being notified about the in condition. She stated in the PTA, on 05/02/12 and and 3:05 PM, revealed, on /12, as she began physical at #1, his/her daughter came and asked if she had noticed to the stated she told the	F	514			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185089	B. WIN			C 05/11/2012		
	ROVIDER OR SUPPLIER TRANSITIONAL CARE	AND REHABILITATION ROSEW		550	EET ADDRESS, CITY, STATE, ZIP CODE 0 HIGH ST. DWLING GREEN, KY 42101		172012	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 514	stated "Resident #1 v Further review of a P revealed "Resident # condition at the end of of change and decline decreased strength, of decreased sitting bala PT, on 05/04/12 at 10 02/17/12, she was av condition in Resident know that the change transient." She state also noted a change and documented the note. An interview with the 05/03/12 and 05/07/1 revealed she spoke v and asked her if she resident. She told me documented there wa Resident #1. The da PTA why no one had PTA told her she did notified, but she had to do by notifying the took her to the DNS's she advised the DNS change in the resider had reported the chal she informed the DNS her feel like she was exaggerating. She si had not made a repor The daughter stated	ghter to the DNS. PTA vas sent out of the facility." T PN, dated 02/21/12, 1 experienced a decline in of last week, nursing notified e in status, left-side neglect, decreased mobility and ance." An interview with the 0:30 AM, revealed, on vare there was a change of #1, and further stated "I e, we noted, was not d she was aware that OT of condition in Resident #1 same in her addendum Resident #1's daughter, on 2 at 8:25 AM and 11:20 AM, with the PTA on 02/21/12, had noticed a change in the e yes, and she had as a change of condition in ughter stated she asked the notified her. She stated the not know why I was not done what she was suppose nurse. She stated the PTA office. She further stated that she had noticed a at on 02/17/12, and that she nage to RN #5. She stated S that the nurse had made	F	514				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185089	B. WIN				C 1/2012
	ROVIDER OR SUPPLIER	AND REHABILITATION ROSEW	l	55	EET ADDRESS, CITY, STATE, ZIP CODE 50 HIGH ST. OWLING GREEN, KY 42101		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 514	evaluation." The first notation rela for Resident #1 in the 02/21/12 at 9:00 AM. Form revealed "Resident is exhibiting to those related to a pocketing food, inabil slight left-sided negle be sent to the hospital physician was made a received to send to the rule out CVA." A review of the Magn (MRI) report, complet "Impression: Acute is around the peripheral changes in the distrib cerebral artery in the The OT Discharge Surevealed "[resident] diregression secondary with patient demonstration to 80 degrees left. [Resident] also whean with suspected wone day observation of Discharge Summary, "treatment initially suddate no progress rela Reason for Discharge requiring hospitalization."	ted to a change of condition medical record was on A Change of Condition lent's family states that the signs and symptoms similar previous CVA, such as ity to focus/concentrate and ct. Requesting the resident I for an evaluation. The aware with a new order e ER for an evaluation to letic Resonance Imaging led on 02/21/12, revealed schemic changes were seen area of chronic ischemic lation of the right middle right temporal parietal lobe." Immary, dated 02/22/12, lemonstrates noted let increased left neglect lating right lateral cervical so, unable to cross midline to with significant left lateral lateral lateral left lateral lateral lateral lateral left lateral	F	514			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ′	ULTIPLE LDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PE	ROVIDER OR SUPPLIER	185089		I	T ADDRESS, CITY, STATE, ZIP CODE	05/1	1/2012	
		AND REHABILITATION ROSEW		550	HIGH ST. WLING GREEN, KY 42101			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 514	Form, dated 03/21/1: conducted a teachab the DNS related to in customer satisfaction employee and the remoment was related communicates a concommunicate with the resident. If your assigned but the family what they treat in house or sen Emergency Room (Esigned by the DNS at A review of a Teachable moment were achable moment were achable moment were achable moment was related accompanied RN #1 Resident #1 with a reachable moment was related accompanied RN #1 Resident #1 with a reachable moment was selected accompanied RN #1 Resident #1 with a reachable moment was related accompanied RN #1 Resident #1 with a reachable moment was related accompanied RN #1 Resident #1 with a reachable moment was selected accompanied RN #1 Resident #1. She accompanied a chapter was selected as the facility of the facility summary, dated 04/Physical Therapist A that she noticed a chapter accompanied RN #1. She accompanied RN #1. She accompanied RN #1. She accompanied RN #1 Resident #1. She accompanied RN #1 she noticed a chapter accompanied RN #1. She accompanied RN #1 she noticed a chapter accompanied RN #1. She accompanied RN #1 she noticed a chapter accompanied RN #1 s	2, revealed the facility ble moment with RN #1 by inproved communication and in. The discussion with an ason for a teachable to, "if therapy staff cern with a resident, ie family after assessing the essment does not indicate a ly is still concerned, oncern to the physician. Ask would like done, whether to d for an evaluation to the ER)." The document was ind RN #1. Able Moment - Education aled the facility conducted a with RN #2 by the DNS ocumentation of a resident's The discussion with an ason for a teachable to, "On 02/17/12 you to do an assessment on exported change in condition. It is your responsibility to isment was documented." signed by the DNS and RN by's Final Investigation 13/12, revealed, on 02/17/12, ssistant (PTA) notified RN #1	F	514				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		185089	B. WING		05/	11/2012
	OVIDER OR SUPPLIER TRANSITIONAL CARE	E AND REHABILITATION ROSEW	550	T ADDRESS, CITY, STATE, ZIP COI HIGH ST. WLING GREEN, KY 42101	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 514	to the window. The daughter approached department, on 02/2 had noticed any chastated that she told she reported a charresident's daughter stated, that on 02/1 advised her that the about a change in c #1. RN #2 accomp Resident #1. They his/her condition. F #1's skin assessme 02/06/12. The area was a Stage III and (cm) by 2.0 cm. Thover 50% but less t Treatment was Sandressing. SRNA #7 different about Res 02/17/12. An intervious (APS) can and requested copi concerning a press stroke. She stated about the concern, investigation at that investigation process there were no negle #1, and unsubstant.	ge 47 Is able to track her all the way PTA stated the resident's ed her in the therapy 21/12, and asked her if she anges in the resident. PTA the resident's daughter that nge to nursing and took the to the DNS's office. RN #2 7/12, RN #1 came to her and erapy had voiced a concern condition regarding Resident anied RN #1 to assess did not notice any changes in RN #2 completed Resident ant upon admission on a on the resident's left buttock measured 2.8 centimeters e area had necrotic tissue han 75% of the wound. attyl with foam and a dry stated she noticed something dent #1 and told RN #1 on friew with the DON, on M, revealed she did not realize m until Adult Protective ne to the facility, on 04/06/12, es of the resident's chart cure sore and the resident's she was informed by APS and she initiated an attime. Through their as, the facility determined ect issues regarding Resident iated the allegation. e DNS, on 05/02/12 at 2:55 are became aware of a ent #1 on the morning of	F 514			

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	185089		A. BUILDIN B. WING		C 05/11/2012		
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW				REET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101	1 30	111/2012	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	(X5) COMPLETION DATE		
F 514	#1's daughter to he "upset about the re the daughter told he the same symptom with his/her prior st looking to the left." was sent out to the and RN #2 and ask 02/17/12. They state of a change of condand RN #2 told me they did not observe the resident. She find document the assess not documenting the she addressed with change of conditions complete a Situation Request (SBAR) for notify the physician re-education with Find completing the SBA being an advocate She stated, "It is not to report. They are just the family report.	ed the PTA brought Resident of office because she was sident's condition." She stated er she was noticing some of sthe resident had exhibited roke, "pocketing food and She stated after the resident hospital, she went to RN #1 ted them, what happened on sted the PTA had advised them dition in Resident #1. RN #1 they did an assessment, and e a change of condition with urther stated they did not assment and had no reason for the assessment. She stated in RN #1 and RN #2 when a in was reported, they were to an Background Assessment them, and then they were to an Background Assessment them, and the them assessment them, and the them assessment them, and the them assessment them. The them as a transfer them as a transfer them as a transfer them. The them as a transfer them as a transfer them as a transfer them. The them as a transfer them as a transfer them as a transfer them. The them as a transfer them as a transfer them as a transfer them.	F 514				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185089			05	C / 11/2012	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW			ST	TREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 514	**The facility impler correct the deficien *The resident's phy notified of resident's 02/21/12 and he/sh * The facility had ar 04/06/12 with IDT to between department service, changes in notification of changes in notification on changes in notification and gunotification on changes in notification on changes in no	mented the following actions to cy: sician/medical director was change of condition on e was sent to the ER. Ad Hoc PI meeting held on preview communication and shifts, customer resident condition and ges in condition. conducted for all staff on the them on the Stop and Watch export book, being an advocate the Situation Background est (SBAR) form with a change idelines for physician ge of condition. Implemented to identify ange in condition. The audit esidents with a change in dated the corrective action	F 51	4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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	185089 B. WING				C 05/11/2012			
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW			'	550	ET ADDRESS, CITY, STATE, ZIP CODE HIGH ST. WLING GREEN, KY 42101	,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	N SHOULD BE COMPLETION DATE		
F 514	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	514				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOWBER.	A. BUII	DING				
		185089	B. WIN	G	C 05/11/		C 1/2012	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW			•	550	T ADDRESS, CITY, STATE, ZIP CODE HIGH ST. WLING GREEN, KY 42101			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	N SHOULD BE COMPLETION DATE		
F 514	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	514				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING			С		
		185089	B. WIN	IG		05/1	1/2012	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW				STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX S	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 514			F	514				
	resident, notify the p	ting the SBAR, assess the hysician, supervisor, ADNS ssment. No concerns were						
	AM, revealed the fact 04/27/12 to follow up The only issue identi	e DNS, on 05/08/12 at 9:35 cility had a PI meeting on o on corrective action plan. ified was two (2) nurses, RN						
	SBAR form. She stathe two (2) nurses we the facility had imple condition audit tool a	missed completing the ated a teachable moment with as completed. She stated mented a change of and had identified all residents ent out of the facility. She						
	stated the facility is of change of condition	continuing to utilize the audit tool.						